

MDR Tracking Number: M5-04-1985-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 3-5-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, therapeutic exercises, myofascial release, and joint mobilization services rendered from 3/10/03 through 6/20/03 and denied with "V", were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On June 29, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Review of the EOBs submitted reveals that payment was recommended in accordance with the 1996 MFG for **CPT codes 99213, 97110, 97250, and 97265** from 3/17/03 through 4/17/03.

Per 2/2/05 telephone contact with Alicia Marquez, representative for the Pain & Recovery clinic, no payment has been made for the disputed services.

Since the insurance carrier did not take final action on the medical bills in accordance with §133.304(a)(b) and (l), and payment was recommended for the services rendered by the audit company, **reimbursement is recommended** as follows:

- CPT code 99213 15 visits X \$48 = \$ 720
- CPT code 97110 (15 visits @ 6 units)(\$35) = \$3150
- CPT code 97250 (15 visits @ 1 unit)(\$43) = \$ 645
- CPT code 97265 (15 visits @ 1 unit)(\$43) = \$ 645

Total recommended reimbursement is \$5160.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 3/17/03 through 4/17/03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 2nd day of February 2005.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

May 24, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-1985-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in Anesthesiology, is licensed by the Texas State Board of Medical Examiners in 1989 and provides health care to injured workers. This is the same specialty as the treating physician. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on ___ when 2000 pounds of metal strips and a cabinet fell on him. The patient required two surgeries to his right thigh and right knee with internal fixation devices. The patient was treated at Pain and Recovery North from 03/17/03 through 03/27/03 and 04/15/03 through 04/17/03.

Requested Service(s)

Office visits, therapeutic exercises, myofascial release and joint mobilization from 03/10/03 through 06/20/03

Decision

It is determined that the office visits, therapeutic exercises, myofascial release and joint mobilization from 03/10/03 through 06/20/03 were not medically necessary for this patient.

Rationale/Basis for Decision

The medical records received do not substantiate the need for physical therapy or manipulation one year after the injury. Physical therapy would be appropriate post operatively after the acute phase of healing. Therefore, the office visits, therapeutic exercises, myofascial release and joint mobilization from 03/10/03 through 06/20/03 were not medically necessary for this patient.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm